



## PMP Enrollment Signature Page

To participate as a PMP in the MDwise Hoosier Healthwise provider network, a provider must sign this page and return it to the provider's delivery system provider relations staff, along with the following forms:

- RBMC/MDwise PMP Enrollment Cover Form
- MDwise Supplemental Enrollment Form

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I, \_\_\_\_\_, agree to participate in the MDwise  
[Print or Type Provider Name Here]

Risk Based Managed Care Program as a Primary Medical Provider (PMP) in the  
\_\_\_\_\_ Delivery System.  
[Delivery System Name Here]

I agree to accept the following number of Hoosier Healthwise members in my

PMP panel: \_\_\_\_\_ [Number must be between 150 – 2000 unless special permission obtained from OMPP.]

I agree to abide by the requirements set forth in the statutes, regulations, and procedures associated with being a PMP in the MDwise Hoosier Healthwise Risk Based Managed Care Program. I understand that these requirements include the terms listed in the attached document entitled “**MDwise PMP Participation Requirements.**”

I agree to accept as full compensation for the care I provide to my assigned members, the amounts set forth under the payment terms I have accepted from my delivery system.

\_\_\_\_\_  
[Provider signature]

\_\_\_\_\_  
[Date]